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*****TESTIMONY IS EMBARGOED UNTIL THE START OF THE
HEARING AT 10:00 AM, WEDNESDAY DECEMBER 4, 2013*****

Testimony on

Challenges of the Affordable Care Act

**Subcommittee on Health
Committee on Ways and Means**

Kevin Brady, Chairman

Jim McDermott, Ranking Member

Wednesday, December 4, 2013

**Grace-Marie Turner, President
Galen Institute**

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Thank you, Chairman Brady, Ranking Member McDermott, and distinguished members of the committee for the invitation to testify today on the impact of the health law and for your diligent oversight of the implementation of this law. My name is Grace-Marie Turner, and I am president of the Galen Institute, a non-profit research organization that I founded in 1995 to advance free-market ideas for health reform.

All eyes have been focused recently on the functionality of the HealthCare.gov website, but many challenges are in store that will impact tens of millions of Americans who are being told their coverage is not affected by the law. They will face significant and costly changes to their health plans and access to doctors, either due to the health law itself or because of subsequent regulations written by the Obama administration.

President Obama said this spring: "...for the 85 to 90 percent of Americans who already have health insurance...their only impact is that their insurance is stronger, better, more secure than it was before. Full stop. That's it. They don't have to worry about anything else."¹

But that will not be their experience. I will focus primarily in my testimony today on the impact on the 150 million Americans who have coverage through employers.

Small businesses are hit especially hard: An estimate in the June 2010 Federal Register predicted that up to 80% of small business plans could be lost because they do not comply with the ACA's requirements.²

Many will find that their new ACA-compliant coverage is more expensive and less attractive, with higher premiums, higher deductibles, and narrower physician networks. Others will lose their employer coverage altogether as employers just give up because they can't afford to provide coverage that complies with the law's expensive mandates.

A recent survey, conducted by Public Opinion Strategies (POS) for the U.S. Chamber of Commerce and the International Franchise Association,³ found that 28% of the businesses offering health coverage plan to drop it in 2015.

More than half of businesses with 40 to 70 employees said they will make personnel decisions to stay below the 50 full-time threshold at which the health law requires them to provide health insurance to workers or pay a penalty. They will cut full-time staff and cut hours of part-time workers. New hires will be temporary or part time, and they will

strictly monitor hours. And the owners say they will stop making efforts to grow or expand their businesses. The survey found that 64% of franchise owners and 53% of non-franchise businesses say the law already has had a negative effect on their businesses.

That means some workers will lose their jobs, others will never get hired, and still others will have their hours cut. These employers report that, even with the one-year delay in the employer mandate, many already have reduced worker hours, cut staff, and/or replaced full-time employees with part-time workers.

Employer mandate: Employers have been providing health insurance for their workers voluntarily for more than 70 years. It's good business because offering health insurance attracts good workers and helps to keep workforces healthy. But the ACA places significant new burdens on employers, including onerous reporting requirements and higher costs because of new mandated benefits, which are forcing many employers to rethink this arrangement.

Most employers want to provide health insurance but not all can afford it and still keep their prices competitive. For companies that operate with very tight profit margins, the mandate to provide health insurance can send their bottom line from black to red. Many of them have no choice but to restructure their businesses to avoid the added costs of either the fines or providing expensive mandated health insurance.

I have spoken with many owners of small businesses, especially businesses in the retail and hospitality industries, facing penalties of \$2,000 to \$3,000 for not providing ACA-compliant health insurance. They tell me that just the penalties will more than consume their profit margins. "It wouldn't even make sense for me to open the doors," one restaurant owner told me.

Companies are being forced to cut hours so they have fewer than 50 full-time workers to avoid the penalties. The health law redefines a full-time work week as 30 hours rather than the traditional 40. Because there is a look-back period, many employers already had begun scaling back employee hours early this year. And many of them cut workers back to 25 hours a week to provide a cushion in case employees' shifts run over.

That is a significant income loss for workers, many of whom are at the lower-end of the income scale. This is a painful and disruptive decision for employers, but they say the law gives them no choice if they want to stay in business at all.

Mandate delay: Businesses got a one-year reprieve from the Obama administration from the reporting requirements involving the employer mandate. But that has not altered their plans to restructure their businesses to comply with the law.

The Congressional Budget Office estimated that as many as 11 million workers could lose their health insurance from employers who pay the penalty rather than the cost of insurance.⁴ Other estimates, such as one from the American Action Forum, suggest that

the number could be as high as 35 million.⁵ Clearly this law is having far-reaching implications.

A one-year delay in the employer mandate will not significantly change the hiring behavior of employers. They won't hire full-time workers while knowing they would have to let those workers go a year from now. If anything, the delay gives employers more time to figure out how to restructure their businesses and workforces to avoid the added costs of the health law.

Does it matter? Some critics have argued that if all businesses are forced to provide health insurance and raise prices, they will not lose customers because all of their competitors will be operating under the same requirements. But customers are smarter than that: They will buy less, substitute more, and more business transactions will simply vanish.

Delay in SHOP exchanges: In yet another blow, the Small Business Health Options Program was supposed to open this year and provide businesses with more choices of health insurance from competing plans. But the administration announced just before Thanksgiving that the online SHOP tool is being delayed for a year and won't be ready until November of 2014. This affects businesses in the 36 states that are relying on the federal government's exchanges.

New taxes increase health costs: In addition, starting next year, virtually every person covered by a health plan will be taxed \$63 – their part of a \$25 billion fund designed to help cushion adverse risk among plans participating in the exchanges.

The ACA also imposes an annual “fee” on health insurance companies that is expected to raise \$8 billion next year and up to \$14.3 billion by 2018. The Congressional Budget Office and industry experts say the tax will largely be passed on to small businesses and consumers buying individual policies in the form of higher premiums.⁶ A report by Oliver Wyman consulting says that the fee will increase premiums by \$150 per employee and \$360 per family in 2014, and that the costs could rise to \$360 per employee and \$890 per family for small businesses.⁷ Self-insured companies are exempt from this tax.

All businesses are impacted: The law is impacting even those with coverage through larger companies: Spousal coverage is being curtailed, deductibles are soaring, and premiums are rising as businesses prepare for the law's taxes, mandates, and regulatory distortions.

Businesses are forced to begin restructuring coverage now in anticipation of the “Cadillac tax” on rich health plans that starts in 2018. The tax will require insurance companies to pay a tax of 40% on the amount by which the total costs of health plans exceed \$10,200 for individuals and \$27,500 for families. The tax is set to take effect in 2018 and will, of course, be passed along in the form of higher premiums. One way that companies already are reshaping their insurance plans is by increasing the amount that employees must pay before their insurance kicks in – from \$1,000 to \$3,000, for example.

The International Foundation of Employee Benefits Plans released a survey in August that showed nearly 17% of those responding already had begun to redesign their health plans to avoid the “Cadillac” tax and another 40% are considering action. Sixty percent of these firms say the looming tax is already having a “moderate” or “significant” influence on benefits decisions for 2014 and 2015.⁸

While I believe that the unlimited tax exclusion for employer-provided health insurance does need to be capped, the ACA does it in a way that exacerbates the distortions by taxing the insurance company providing the coverage. If employers had more flexibility in structuring their health benefits to accommodate a tax cap, they would be able to engage their employees as partners rather than adversaries in finding more affordable health insurance arrangements.

Large employers who self insure are exempt from the health insurance tax, but they are subject to this \$63 per-person tax to raise \$25 billion to cushion the risk of health plans operating inside the exchanges.

Other provisions, such as allowing adult children to stay on their parents’ policies up to age 26, no lifetime or annual limits on policy payouts, and providing “free” preventive care, are costing large companies tens of millions of dollars a year in added health costs.

The ACA’s mandates and rules impacting businesses, on top of the higher costs resulting from the new taxes, give employers added incentive to drop coverage for their workers and simply pay the penalties.

Other provisions aren’t delayed: The delay of the reporting requirements for the employer mandate does not mean that businesses can take a year off from other provisions of the law slated to go into effect in or before 2014, including:

- New federal rules on deductible maximums and out-of-pocket maximums
- 90-day maximum on eligibility waiting periods
- Elimination of lifetime and annual limits (including expiration of waivers that permitted certain “mini-med” plans and stand-alone Health Reimbursement Arrangements to stay in place through plan years beginning in 2013)
- New wellness plan rules
- Fair Labor Standards Act notice to employees informing them of the availability of the new health insurance exchanges
- Summary and benefit coverage notice that must meet rigid federal standards
- \$2 fee to fund the Patient-Centered Outcomes Research Trust Fund
- Preventive care services with no cost sharing

These businesses are receiving no relief from these requirements, which add compliance costs and distract them from their core activities. This is severely hampering the jobs recovery our economy so desperately needs.

Business response: Businesses clearly are struggling to respond to the mountain of costs and new compliance rules imposed by the ACA. Susan Carrick, head of human resources at the University of Virginia, said: “When medical expenses go up, which they have for us, then we have two choices: We can either increase premiums, or we can reduce what we pay out in the way of benefits.” The law is expected to add \$7.3 million to the cost of the university’s health plan in 2014 alone.⁹

Individuals impacted: While I have focused primarily on those with employer coverage, it is important to recognize the millions of people who are individually insured and feel the rug has been pulled out from under them. The president repeatedly has disregarded the 5% of people with “junk,” “substandard,” “sub-par” and “bad-apple” insurance – people who purchase individual health insurance policies for themselves and their families. These are people who have taken the initiative to seek out policies and pay premiums with after-tax dollars to provide health insurance for themselves and their families. They are the first targets of the health law.

The president says they represent “only” 5% of Americans. But that is about 15 million people – hardly an insignificant number.

And finally, the uninsured. The 15% of Americans who are uninsured are the *raison d’etre* of the law’s coverage expansion. But even they don’t fare well. Of the 48 million people in the U.S. who are without health coverage, at least 30 million will remain uninsured by 2016. The others are either going to be enrolled in Medicaid or forced to navigate the exchange maze.

The problems with enrollment in the federal and most state exchanges make it increasingly likely exchanges will have a disproportionate number of enrollees who are sicker and who have higher health costs.

The exchanges could well become default high-risk pools. Premiums likely will become even more expensive next year (and beyond), driving out the young, healthy people needed to subsidize older, sicker people. The Obama administration signaled this concern when it announced it will delay the beginning of the 2015 enrollment season until after the 2014 elections, apparently to hide the next wave of sticker shock.

Near-term policy fixes. I believe that the ACA will continue to face serious problems and cause continuing dislocations in our health sector and economy, but this is not the forum for a discussion of long-term solutions. There are immediate problems and dislocations which I believe call for congressional action:

1. **Keep your coverage:** Many people are genuinely frightened about the loss of their private insurance policies and the difficulty of finding an affordable alternative. People

who are in the midst of chemotherapy, who have a child with chronic illness, or have other serious health needs are desperate. The House has passed the “Keep Your Health Plan Act,” and Sen. Ron Johnson has introduced companion legislation in the Senate. The legislation would grandfather all existing plans, a vital step in protecting millions of people from losing the coverage they have now.

2. Temporary safety net: High-risk pools operate in about 35 states and insure about 200,000 people, typically those with medical conditions that make it hard for them to find other coverage. In addition, an estimated 100,000 people have enrolled in the ACA’s Temporary High Risk Pool Program, which closes at the end of this year. People receiving coverage through those plans will not have anywhere to go if they cannot enroll on the exchanges.

Many states have closed their state risk pools, but are considering reopening them, at least temporarily. The federal government also hasn’t ruled out extending its federal risk pools, but doing so would require congressional approval for the additional funding required. On average, state high-risk pool participants incur about \$11,000 a year in medical claims, according to the National Association of State Comprehensive Health Insurance Plans.¹⁰ Those enrolled in the federal high risk pools incur an average of \$32,108 a year in medical costs.¹¹

I believe Congress and the states would be well advised to keep these safety-net programs in place while a better and more sustainable system is created for people with pre-existing conditions.

3. Consumer-centered health insurance: One of the things we see from this rollout is that people like and value the private health plans they have chosen, balancing cost against benefits. But we need to more competition and flexibility in policy design as well as sensible rules that get the incentives right for both companies and consumers. Insurance rules that guarantee renewal of policies at affordable rates tighter with restructuring existing tax credits could begin to build a bridge to a market-based system.

I thank you for the opportunity to testify today and look forward to your questions and discussion.

ENDNOTES

¹ A transcript of the News Conference by the President on April 30, 2013, can be found at <http://www.whitehouse.gov/the-press-office/2013/04/30/news-conference-president>

² “Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act; Interim Final Rule and Proposed Rule,” Federal Register, June 17, 2010 (<http://www.gpo.gov/fdsys/pkg/FR-2010-06-17/pdf/2010-14488.pdf>)

³ “Presentation of Findings from National Research Conducted Among Business Decision-Makers,” Public Opinion Strategies, September-October 2013 (<http://www.uschamber.com/sites/default/files/reports/IFACHamberFinal.pdf>)



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- ⁴ “CBO and JCT’s Estimates of the Effects of the Affordable Care Act on the Number of People Obtaining Employment-Based Health Insurance,” Congressional Budget Office, March 2012 (http://cbo.gov/sites/default/files/cbofiles/attachments/03-15-ACA_and_Insurance_2.pdf)
- ⁵ “Labor Markets and Health Care Reform: New Results,” Douglas Holtz-Eakin & Cameron Smith I, American Action Forum, May 27, 2010 (http://americanactionforum.org/sites/default/files/OHC_LabMktsHCR.pdf)
- ⁶ “An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act,” Congressional budget Office, November 30, 2009 (<http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/107xx/doc10781/11-30-premiums.pdf>)
- ⁷ Carlson, Chris, FSA MAAA, “Estimated Premium Impacts of Annual Fees Assessed on Health Insurance Plans,” Oliver Wyman, October 31, 2011 (<http://ahip.org/Issues/Documents/2011/Oliver-Wyman-Study--Estimated-Premium-Impacts-of-Annual-Fees-Assessed-on-Health-Insurance-Plans.aspx>)
- ⁸ “2013 Employer-Sponsored Health Care: ACA’s Impact,” International Foundation of Employee Benefit Plans, August 2013 (<http://www.ifebp.org/pdf/research/2103ACAImpactSurvey.pdf>)
- ⁹ Needleman, Sarah, “For Small Businesses, a Hidden Tax in Health Care?” Wall Street Journal, November 22, 2013 (<http://online.wsj.com/news/articles/SB10001424052702304607104579210133556240634>)
- ¹⁰ Radnofsky, Louise, “High-Risk Patients Fuel More Health-Law Worry,” Wall Street Journal, November 17, 2013 (<http://online.wsj.com/news/articles/SB10001424052702303559504579202953343942182>)
- ¹¹ “Covering People with Pre-Existing Conditions: Report on the Implementation and Operation of the Pre-Existing Condition Insurance Plan Program,” Centers for Medicare and Medicaid Services, January 31, 2013 (http://www.cms.gov/CCIIO/Resources/Files/Downloads/pcip_annual_report_01312013.pdf)

